Montana Medicaid Claim Jumper

Montana Medicaid Clients to Receive Disease Management, Nurse Triage Services

Medicaid clients throughout the state soon will receive disease management and nurse advice services through a new program provided by the Montana Department of Public Health and Human Services. The goal of the asthma, heart failure, cancer, chronic pain and diabetes disease management program and the nurse triage service is to increase the health and wellness of participants while lowering costs for the state.

Approximately 75,000 of Montana's Medicaid clients will have access to both programs which are administered by McKesson Corporation.

Rural populations face tremendous burdens associated with chronic conditions. People often must travel significant distances to an emergency room or to see their doctor. These services can help improve quality of life by helping clients stay healthy no matter where they live or the distance of medical services from their home.

Participants in the disease management program will receive one-on-one counseling with a registered nurse and health information about asthma, heart failure, diabetes, cancer, and chronic pain depending on a client's specific health needs. In addition, participants typically receive written information about their disease state and suggestions of ways to control symptoms at home.

If disease symptoms worsen, a nurse contacts the client's physician with the information.

In addition to disease management, Medicaid clients will have access to a 24x7 nurse triage line, also staffed by registered nurses. The nurses provide advice for symptomatic medical conditions. These recommendations can range from treating a minor injury at home to receiving immediate emergency care.

The registered nurses involved in the program work in McKesson's care centers or are community-based nurses who travel to some of the clients' homes to administer the program.

Reference Lab Billing

Medicaid reimbursement policy provides guidance for providers to bill for the services they render. Administrative Rule of Montana (ARM) 37.85.406 (16) reads:

A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana Medicaid program manual and is in compliance with any supervision requirements in state law or rule governing the provider's professional practice and the practice of assistants and aides. Other providers, including but not limited to hospitals, nursing facilities and home health agencies, may bill for and receive reimbursement for services provided by supervised persons in accordance with the medicaid rules and manual and any supervision requirements in state law or rule governing professional practice.

For example, when a provider performs a procedure that involves a biopsy, the provider who performs the pathology of the biopsy would need to bill for their service. The fee schedule on the web has indicators of which codes can be split billed and which cannot. These services, as all others, are subject to post-payment review by the Quality Assurance Division.

Manual Pricing for Mental Health Services

Due to the large volume of mental health service claims pending for manual pricing, these claims will no longer be manually priced on-line, i.e., claim-by-claim. The manual pricing was required as a result of the emergency rate reduction that was in effect for the period January 15, 2003 through June 30, 2003. Instead, since these dates of service have now passed, any claims for this period will be adjusted through the system at the end of the month. This change took effect October 13, 2003.

Adjusting these claims following regular processing will help ease the backlog of pended claims and allow for more timely reimbursement for mental health services subject to manual pricing.

Attention PASSPORT Providers!

As of November 1, 2003, the PASSPORT Provider hotline is moving to ACS! Now there is just one number to call to get answers to all your Medicaid questions, 1-800-624-3958 (or 406-442-1837 in Helena and out-of-state). After November 1, callers to the old PASSPORT number will be instructed to call the above numbers. ACS looks forward to providing outstanding service to PASSPORT providers.

Correction: Family Care Services Modifier

In the September *Claim Jumper,* the modifier for Permanency Therapeutic Family Care was reported as "HD." This is incorrect. The correct modifier is "HE."

Cost Avoidance: Pharmacy and Dental Providers

On January 1, 2004, the Department of Public Health & Human Services will no longer allow pharmacy and dental providers to submit claims to Medicaid before submitting the claim to an applicable client's Other Health Insurance (OHI). The Cost Avoidance waiver, which allowed the Department to "pay and chase" claims for clients with OHI, expires on that date. Providers will be required to bill the client's OHI carrier prior to submitting the claim to Medicaid. Further policy statements for each program will follow in the coming weeks.

Any questions can be directed to ACS Provider Relations at (406) 442-1837 or (800) 624-3958.

EPSDT/Family Planning Indicator

The EPSDT/family planning indicator code` "5" is no longer valid under HIPAA guidelines. Providers should use "4" on paper claims. For electronic claims, pregnancy should be indicated by entering the appropriate pointer.

HIPAA Reminder

Providers should plan to visit the "HIPAA Update" webpage (*www.mtmedicaid.org)* at least weekly during the next few months for the latest information on HIPAA implementation activities.

Electronic Claims with Paper Attachments

As per HIPAA provisions, providers may submit claims electronically even if the claim requires paper documentation, such as a Sterilization Form, Hysterectomy Acknowledgement Form, FA-455 and other forms currently required for processing.

Providers submitting this type of claim must enter a paperwork attachment indicator in the 837 X12N transaction along with an electronic tracking number. Each paper attachment must be submitted accompanied with a Paper Attachments Cover Sheet which includes the tracking number and the provider number, client ID number, and date of service.

The tracking number can either be the preferred format that uses the provider number, client ID number, and date of service, or it can be a custom format generated by vendor software or a clearinghouse as long as the tracking number on the cover sheet matches the tracking number in the X12N transaction.

The Paper Attachments Cover Sheet is available on the forms section of the Provider Information website (*www.mtmedicaid.org)* or in the ANSI ASC X12N 837 Companion Guide (available at *http://www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm).*

An electronic claim indicating paper attachments will be pended for up to 30 days until the attachment(s) can be reconciled with the claim and processed appropriately. If the attachment(s) is not received, the claim will deny. Attachments without the cover sheet or cover sheets without sufficient information will be returned if a return address is included with the submission.

Prospective Payment Outpatient Hospitals (excludes CAHs)

With the change in outpatient reimbursement to APCs, modifiers become important to receiving proper payment. The following is a guide to modifier use for APC billing; however, it is not an all-inclusive guideline. To assure proper use of modifiers, you must read the long definitions in your CPT coding books and code appropriately.

General Modifier Use

- Not all HCPCS codes require a modifier.
- Do not use a modifier if the narrative definition of a CPT code indicates the procedure applies to different body parts (i.e., code 11600, excision of lesion from trunks, arms, etc.). Code for appropriate centimeters or diameters (ect.) per long descriptions in CPT coding book.
- Do not use a modifier if the narrative definition of a CPT code indicates multiple occurrences (i.e., the code definition indicates two to four lesions, or the code indicates multiple extremities).
- Medicaid will only apply one modifier per line for UB-92 claim forms.
- The modifier that will "affect pricing" should be listed first.
- The use of modifiers applies to services/procedures performed on the same calendar day.
- When it is appropriate to use a modifier, the most specific modifier should be used first. For example, when modifiers E1-E4, FA-F9, LC, RC, and TA-T9 apply they should be used before modifiers LT, RT, or 59.

Modifier for E/M Services

- Modifier 25 is used to indicate a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service."
  - This modifier may be used only with E/M service codes within the following code ranges under OPPS: 92002-92014, 99201-99499, and G0101 and G0175.
  - This modifier should always be reported with the emergency department E/M codes 99281-99285 when provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/ surgical procedure.
- Modifier 27 defined as "multiple outpatient hospital E/M encounters on the same date."
  - This modifier should be used with E/M codes within the range of 92002-92014, 99201-99499, G0101, and G0175.
  - Hospitals use this modifier on the second and subsequent E/M code when more than one E/M service is provided to indicate that the E/M service is a separate and distinct E/M encounter from the service previously provided on the same day in the same or different hospital setting.

Modifier for Bilateral Procedures

- Modifier 50 applies to surgical procedures (CPT codes 10040-69990) and to radiology procedures performed bilaterally.
  - Modifier 50 is used to report bilateral procedures performed in the same operative session. Identify that a second (bilateral) procedure has been performed by adding modifier 50 to the procedure code. Do not report two line items to indicate a bilateral procedure.
  - Do not use modifier 50 with surgical procedure identified by their terminology as "bilateral" (for example 27395 or 52290).
  - Modifier 50 applies to any bilateral procedure performed on both sides at same session.
  - Do not use RT and LT when modifier 50 applies. Report only one unit of service in FL 46 when modifier 50 is reported.

Modifiers for Reduced or Discontinued Procedures

- When used to indicate a discontinued procedure, modifiers 52, 73, and 74 are used for surgical procedures and certain diagnostic procedures only. These modifiers are not used to indicate discontinued radiology procedure.
- Modifier 52, when it refers to reduced services and modifiers 59, 76, 77, HCPCS Level II modifiers apply to radiology services.
- When a radiology procedure is reduced, the correct reporting is to assign a code to the extent of the procedure performed. Modifier 52 (reduced service) is used only to report a radiology procedure that has been reduced and no other code exists to report what has been done. *(Continued on next page.)*

- Modifier 73 is used to report a discontinued outpatient hospital procedure prior to the administration of anesthesia. (Modifier 73 replaces modifier 52 for hospital reporting of discontinued surgical services or procedures; however, modifier 52 remains valid for reporting reduced radiology procedures.)
  - Never report elective cancellation of procedures. The modifier is used to report circumstances where the well being of the patient is threatened. The patient must be taken to the room where the procedure is to be performed to report modifier 73 or 74 as appropriate.
  - If available use a CPT code that classifies the extent of the procedure performed instead of reporting the intended procedure. When one or more of the planned procedures are completed, report the completed procedures as usual. Any other procedure planned but not started is not reported. When none of the procedures are completed, report the first planned procedure with modifier 73.
  - Modifier 73 is used only with surgical procedure codes. It should not be used to indicate a discontinued radiology procedure.
- Modifier 74 is used to report a discontinued outpatient hospital procedure after the administration of anesthesia or after the procedure was started (i.e., incision made, intubation started, scope inserted).
  - Never report elective cancellation of procedures. The modifier is used to report circumstances where the well being of the patient is threatened. The patient must be taken to the room where the procedure is to be performed to report modifier 73 or 74 as appropriate.
  - If available use a CPT code that classifies the extent of the procedure performed instead of reporting the intended procedure. When one or more of the planned procedures are completed, report the completed procedures as usual. Any other procedure planned but not started is not reported. When none of the procedures are completed, report the first planned procedure with modifier 74.
  - Modifier 74 is used only with surgical procedure codes. It should not be used to indicate a discontinued radiology procedure.

Modifiers for Clinical Diagnostic Laboratory Services

- Modifier 91 may be used to indicate that a test was performed more than once on the same day for the same patient only to obtain multiple results in the course of treatment. It may be used only for laboratory tests paid under the clinical diagnostic laboratory fee schedule.
  - This modifier may not be used when tests are rerun to confirm initial results, due to testing problems with specimens or equipment or other reason when a normal, one time reportable result is required.
  - This code may not be used with other CPT/HCPCS codes to describe a series of test results (e.g. glucose tolerance tests).

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March 2003

2004 Spring Medicaid Provider Fair

Mark your calendars for April 27 & 28, 2004. That is when the Spring Medicaid Provider Fair will be held at the Great Northern Hotel in Helena. Further details and registration information will be published in an upcoming issue of the *Claim Jumper* and will be posted at *www.mtmedicaid.org.*

Recent Publications

The following are brief summaries of publications regarding recent program policy changes. For details and further instructions, download the complete notice from the Provider Information website (http://www.mtmedicaid.org). Select Notices and Replacement Pages, and then select your provider type for a list of current notices. If you cannot access this information, contact provider relations.

New Notices

10/01/03 Prospective Payment Hospitals

Change in inpatient rehabilitation PA
Update to emergency department diagnosis list

10/01/03 School-based Providers

Manual replacement pages with billing corrections

09/30/03 Pharmacy Providers

NCPDP 5.1 delayed until October 16, 2003

09/16/03 Hospitals, Physicians, Mid Levels, RHCs, FQHCs

Physician Manual replacement pages for hysterectomies and prescription drug PA update

09/05/03 Pharmacy Providers

Verifying eligibility with the *Montana Access to Health Medicaid* hard card

08/29/03 All Providers

PASSPORT implementation in Prairie County

WINASAP Training

ACS provider relations field representatives will be conducting one-on-one and small group WINASAP2003 training sessions in December. The free WINASAP2003 software is replacing the ACE$ electronic Medicaid claim submission software and will allow providers to submit HIPAA-compliant electronic claims. The software, enrollment forms and instructions can be downloaded at the ACS EDI Gateway website at *www.acs-gcro.com* or through the EDI link at *www.mtmedicaid.org.* Providers must enroll with EDI prior to submitting electronic claims via WINASAP2003. Providers who are currently submitting their claims on paper are encouraged to take advantage of this convenient, free service to submit claims electronically.

Providers interested in WINASAP2003 training must call Michael Mahoney at 406-457-9532 or Maria Rogne at 406-457-9531 to schedule a one-hour session. Space is limited so schedule an appointment early.

- **December 1, 2004**, 8 a.m. – 5 p.m. *(One-hour sessions, appointment required)*
  Entre Technology Services
  2727 Central Avenue
  Billings, MT

- **December 3, 2004**, 8 a.m. – 5 p.m. *(One-hour sessions, appointment required)*
  Flathead Valley Community College
  777 Grandview Drive
  Kalispell, MT

- **December 5, 2004**, 8 a.m. – 5 p.m. *(One-hour sessions, appointment required)*
  DPHHS Computer Training Center
  2905 N. Montana Avenue
  Helena, MT

Montana Medicaid
ACS
P.O. Box 8000
Helena, MT 59604

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Key Contacts

Provider Information Website: http://www.mtmedicaid.org
ACS EDI Gateway Website: http://www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm
ACS EDI Help Desk (800) 987-6719
Provider Relations (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax
TPL (800) 624-3958 Montana
(406) 443-1365 Helena and out-of-state
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility:
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 480-6823
Prior Authorization:
DMEOPS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

Provider Relations
P.O. Box 4936
Helena, MT 59604

Claims Processing
P.O. Box 8000
Helena, MT 59604

Third Party Liability (TPL)
P.O. Box 5838
Helena, MT 59604